Referral for Infant and Child Development Program (ICDP) at Niagara Children's Centre

Section 1: Healthcare Provider/Referral Source Information

Consent for referral was received from Parent/Legal Guardian Yes☐
Child lives in the Niagara Region Yes☐
Date of Referral: _____
Person referring: First Name:_____ Last Name: _____
Organization: _____
Referral contact #: _____ Fax: _____
Signature: _____ or ☐electronically signed

Section 2: Child's Information (please print)

Child's First Name:_____ Last Name: _____
Date of Birth (YYYY-MM-DD):_____
Gestational Age: _____ Birth weight in kg:_____ Gender: _____

Section 3: Parent/Legal Guardian & Contact Information (please print)

Custody Status: Joint☐ Maternal sole☐ Paternal sole☐ Kinship☐ CAS/FACS☐
Does child live with Parent/Legal Guardian: Yes☐ No☐
Primary language spoke at home:_____ Interpreter required?: Yes ☐No☐
Parent/Legal Guardian's First Name:_____ Last Name: _____
Parent's Address:_____ City: _____
Contact#: _____ Email: _____

If child does not live with Parent/Legal Guardian, please provide the Child's address:
Child's Address: _____
City: _____Postal Code:_____

Section 4: Reason for Referral

Prematurity	Suspected	Confirmed
Prematurity 34 weeks and under (all eligible)		☐
Prematurity 35-36 weeks (1+ risk factor required)		☐
Risk Factors		
No prenatal care		☐
Prenatal or perinatal complications; Specify: _____		☐
Multiple pregnancy/birth		☐
Prenatal substance exposure and/or Neonatal abstinence syndrome	☐	☐
Seizures	☐	☐
Developmental delay	☐	☐
▪ Feeding	☐	☐
▪ Motor/Physical development	☐	☐
▪ Communication/Engagement	☐	☐
Hearing Specify: _____	☐	☐
Vision Specify: _____	☐	☐
Genetic condition Specify: _____	☐	☐
Metabolic condition Specify: _____	☐	☐
Neurological condition Specify: _____	☐	☐
If applicable, additional information (e.g other diagnoses, biological, psychosocial risks or relevant family history)		

Section 5: Professional Contacts

Healthy Babies/Healthy Children	Name:		Contact #:	
Primary Physician/NP	Name:		Contact #:	
Social Worker	Name:		Contact #:	
FACS Contact	Name:		Contact #:	
De dwa da dehs nye>s	Name:		Contact #:	
Centre de santé Communautaire	Name:		Contact #:	
Other	Name:		Contact #:	
Other	Name:		Contact #:	
Other	Name:		Contact #:	